

**Subject:** Studies in the News: (February 25, 2010)

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## Studies in the News for



## California Department of Mental Health

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### ANTIPSYCHOTIC DRUGS

**Trends in Antipsychotics Purchases and Expenses for the U.S. Civilian Noninstitutionalized, 1997 and 2007. By Marie N. Stagnitti, Agency for Healthcare Research and Quality. (The Agency, Rockville, Maryland) January 2010. 3 p.**

[“This Statistical Brief examines trends in purchases and expenses for outpatient antipsychotics from 1997 to 2007. The estimates included in this Brief are derived from

1997 and 2007 data for the U.S. civilian noninstitutionalized population from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC). For antipsychotics, the Brief compares 1997 and 2007 total expenses, purchases, and persons purchasing, as well as the average total, out of pocket, and third party expenditure per person and per purchase. For this Brief, the Multum Lexicon therapeutic classification system produced by Cerner Multum was used to determine the drugs included in the antipsychotics therapeutic subclass. Antipsychotics are used to treat schizophrenia and schizophrenia related conditions. Conventional "typical" antipsychotics have been available since the mid-1950s. In the 1990s, new antipsychotic medications were developed. These new medications are referred to as second generation or "atypical" antipsychotics.<sup>1</sup> Only prescribed medicine purchases in an outpatient setting are included in the estimates presented in this Brief. Prescription medicines administered in an inpatient setting or in a clinic or physician's office are excluded from the estimates in this Brief. Expenses are in real dollars; estimates for 1997 were adjusted to 2007 dollars based on the Gross Domestic Product (GDP) Price Index ([http://www.meps.ahrq.gov/mepsweb/about\\_meps/Price\\_Index.shtml](http://www.meps.ahrq.gov/mepsweb/about_meps/Price_Index.shtml)) All differences discussed in the text are statistically significant at the 0.05 level.”]

Full text at:

[http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/st275/stat275.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st275/stat275.pdf)

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## COMMUNITY CARE AND MENTAL ILLNESS

**“The Effectiveness of Community Care for People with Severe Mental Disorders.”**  
**By Katarzyna Prot-Klinger and Malgorzata Pawlowska, Institute of Psychiatry and Neurology, Warsaw, Poland. IN: Archives of Psychiatry and Psychotherapy, vol. 11, no. 4 (December 2009) pp. 43-49.**

[“Background. A constant effort is observed all over the world to displace treatment from mental hospitals and other long stay institutions to a community form of care. Community care is poorly developed in Poland. This induces surveys estimating the effectiveness of community care recently formed. Aim. The aim was to estimate the efficacy of a new community model of treatment of patients with schizophrenia. It was expected that community care decreases hospitalizations and enables better functioning in the environment, which in turn improves their quality of life. Method. The study was carried out on 37 patients and 25 caregivers assessed at the referral to the community care and after one year in care. The study uses PANSS, Birchwood Scale and the Quality of Life Scale. Polish questionnaires: Family Burden Questionnaire and Questionnaire of Burdensome Behaviour were used to measure family burden in the patients' and their relatives' views. The focus group was used to evaluate treatment satisfaction. Cost assessment was made using the data form Administrative Departure of the institution. Results. Improvement in psychic state, contacts with family and satisfaction from life were achieved. Reduction in destructive behaviours was noted. Improvement occurred in withdrawal and undertaking social roles. Reduction in costs occurred due to a major decrease in the length of hospitalisations. Conclusions. Community care enables social

inclusion through improving social functioning and subjective quality of life and sense of freedom. The community model is cost effective as a result of reduction of hospitalisations.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47480522&site=ehost-live>

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## CRIMINAL JUSTICE SYSTEM

**“Transitions Clinic: Creating a Community-Based Model of Health Care for Recently Released California Prisoners.” By Emily A. Wang, San Francisco Department of Public Health, and others. IN: Public Health Reports, vol. 125 (March-April 2010) pp. 171-177.**

[“Most California prisoners experience discontinuity of health care upon return to the community. In January 2006, physicians working with community organizations and representatives of the San Francisco Department of Public Health’s safety-net health system opened the Transitions Clinic (TC) to provide transitional and primary care as well as case management for prisoners returning to San Francisco. This article provides a complete description of TC, including an illustrative case, and reports information about the recently released individuals who participated in the program. From January 2006 to October 2007, TC saw 185 patients with chronic medical conditions. TC patients are socially and economically disenfranchised; 86% belong to ethnic minority groups and 38% are homeless. Eighty-nine percent of patients did not have a primary care provider prior to their incarceration. Preliminary findings demonstrate that a community-based model of care tailored to this disenfranchised population successfully engages them in seeking health care.” **NOTE: Please contact the California State Library for an electronic copy of this article.**]

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## DISPARITIES

**“Psychiatrists’ Attitudes Toward and Awareness about Racial Disparities in Mental Health Care.” By Julie B. Mallinger, Georgetown University Law Center, and J. Steven Lamberti, University of Rochester. IN: Psychiatric Services, vol. 61, no. 2 (February 2010) pp. 173-179.**

[“*Objective:* Psychiatrists may perpetuate racial-ethnic disparities in health care through racially biased, albeit unconscious, behaviors. Changing these behaviors requires that physicians accept that racial ethnic disparities exist and accept their own contributions to disparities. The purposes of this study were to assess psychiatrists’ awareness of racial disparities in mental health care, to evaluate the extent to which psychiatrists believe they contribute to disparities, and to determine psychiatrists’ interest in participating in disparities-reduction programs. *Methods:* A random sample of psychiatrists, identified

through the American Psychiatric Association's member directory, was invited to complete the online survey. The survey was also distributed to psychiatrists at a national professional conference. *Results:* Of the 374 respondents, most said they were not familiar or only a little familiar with the literature on racial disparities. Respondents tended to believe that race has a moderate influence on quality of psychiatric care but that race is more influential in others' practices than in their own practices. One fourth had participated in any type of disparities-reduction program within the past year, and approximately one-half were interested in participating in such a program. *Conclusions:* Psychiatrists may not recognize the pervasiveness of racial inequality in psychiatric care, and they may attribute racially biased thinking to others but not to themselves. Interventions to eliminate racial-ethnic disparities should focus on revealing and modifying unconscious biases. Lack of physician interest may be one barrier to such interventions.”]

Full text at:

<http://psychservices.psychiatryonline.org/cgi/reprint/61/2/173>

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## HEALTH CARE ISSUES

**“Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006.”**  
**By Kenneth E. Thorpe and others, Emory University. IN: Health Affairs published online (February 18, 2010) pp. 1-10.**

[“Increased spending on chronic diseases among Medicare beneficiaries is a key factor driving the overall growth in spending in the traditional Medicare program. Our results highlight important changes in the medical conditions accounting for the rise in spending among beneficiaries over time. The most notable changes were in spending on a handful of chronic conditions: diabetes, kidney disease, hyperlipidemia, hypertension, mental disorders, and arthritis....

The U.S. health system remains predicated on providing acute, episodic care that is inadequate to address the altered patterns of disease now facing the American public. Our results highlight the need for prevention and care outside doctors' offices and hospitals designed to address the changing needs of patients at risk for or living with chronic disease and, often, multiple comorbidities. As Congress and the Obama administration, along with providers, insurers, and consumers, continue their efforts to reshape the U.S. health system, they must address these changed health needs through evidence-based preventive care in the community, care coordination, and support for patient self-management.”]

Full text at:

<http://content.healthaffairs.org/cgi/content/full/hlthaff.2009.0474v1>

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**International Developments in Self-Directed Care. By Vidhya Alakespn, U.S. Department of Health and Human Services. (The Commonwealth Fund, New York, New York) February 17, 2010. 12 p.**

[“Self-directed care is an alternative way of delivering services that seeks to empower participants by expanding their degree of choice and control in selecting services. Over the last decade, it has been widely adopted internationally in home and community-based long-term care for people with physical and cognitive disabilities and for seniors. It has been shown to improve satisfaction with services, improve quality of life, and reduce costs compared with services from an agency. A small number of pilot programs are now experimenting with self-directed care in other areas; for example in the management of serious mental illness and other chronic conditions. If positive findings from long-term care can be replicated, self-directed care can make an important contribution to improving health care quality and effectiveness. This issue brief examines a range of innovative self-directed care programs in England, Germany, the Netherlands, and the United States.”]

Full text at:

[http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370\\_Alakeson\\_intl\\_devel\\_selfdirected\\_care\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Feb/1370_Alakeson_intl_devel_selfdirected_care_ib_v2.pdf)

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## **SEXUAL OFFENDERS**

**“Sentencing of Male and Female Sex Offenders: Australian Study.” By Rebecca Deering and David Mellor, Deakin University, Melbourne, Australia. IN: *Psychiatry, Psychology, & Law*, vol. 16, no. 3 (December 2009) pp. 394-412)**

[“Research suggests that, in line with the chivalry hypothesis of female offending, a range of mitigatory factors such as mental health problems, substance abuse, and personal experiences of abuse are brought into play when women who offend against children are brought to trial. This is reflected in sentencing comments made by judges and in the sanctions imposed on the offenders, and as a result female offenders are treated differently to male offenders. The current study investigated this in an Australian context. Seven cases of female-perpetrated child sexual abuse were identified over a 6-year period through the Australian database. Seven cases of male-perpetrated child sex abuse matched as far as possible to these were identified. Court transcripts were then located and sentencing comments and sanctions imposed were analyzed. All offenders were sentenced to imprisonment, but in general the women were more likely than the men to receive less jail time and lower non-parole periods because their personal backgrounds or situation at the time of the offending (i.e., difficulties with intimate relationship, male dependence issues, depression, loneliness and anger) were perceived as worthy of sympathy, and they were considered as likely to be rehabilitated. Further investigations are needed to support these findings.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=44653581&site=ehost-live>

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**“Sex Offender Treatment in the United States: The Current Climate and Unexpected Opportunity for Change.” By Kelsie Tregilgas, Tulane University. IN: Tulane Law Review, vol. 84, no. 3 (2010) pp. 729-757.**

[“While sex-offender laws and policies have garnished unquestioning support from a sector of the population largely uneducated about the specifics of their implementation and effects, they have frequently been criticized by scholars, mental health professionals, and others familiar with the realities of contemporary sex-offender treatment. This Comment explores many of these criticisms, from widespread societal implications and efficacy concerns to the frequently disproportional practical difficulties faced by individual offenders and their families. This Comment recognizes that because of the general population's lack of awareness about these issues, lawmakers who would otherwise support sensible and necessary modification of the existing system are often unable to do so without risking political suicide. As a result, this Comment suggests that legislators seize the opportunity presented by the current economic crisis and use the umbrella of budgetary constraints to restructure sex-offender laws and policies in order to inject into the system maximum financial economy, functionality, and justice.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=47574228&site=ehost-live>

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### STIGMA

**“The Stigma of Childhood Mental Disorders: A Conceptual Framework.” By Abraham Mukolo and others, Vanderbilt University. IN: Journal of the American Academy of Child & Adolescent Psychiatry, vol. 49, no. 2 (February 2010) pp. 92-103.**

[“**Objective:** To describe the state of the literature on stigma associated with children’s mental disorders and highlight gaps in empirical work. **Method:** We reviewed child mental illness stigma articles in (English only) peer-reviewed journals available through Medline and PsychInfo. We augmented these with adult-oriented stigma articles that focus on theory and measurement. A total of 145 articles in PsychInfo and 77 articles in MEDLINE met search criteria. The review process involved identifying and appraising literature convergence on the definition of critical dimensions of stigma, antecedents, and outcomes reported in empirical studies. **Results:** We found concurrence on three dimensions of stigma (negative stereotypes, devaluation, and discrimination), two contexts of stigma (self, general public), and two targets of stigma (self/individual, family). Theory and empirics on institutional and self stigma in child populations were

sparse. Literature reports few theoretic frameworks and conceptualizations of child mental illness stigma. One model of help seeking (the FINIS) explicitly acknowledges the role of stigma in children's access and use of mental health services. **Conclusions:** Compared with adults, children are subject to unique stigmatizing contexts that have not been adequately studied. The field needs conceptual frameworks that get closer to stigma experiences that are causally linked to how parents/caregivers cope with children's emotional and behavioral problems, such as seeking professional help. To further research in child mental illness, we suggest an approach to adapting current theoretical frameworks and operationalizing stigma, highlighting three dimensions of stigma, three contexts of stigma (including institutions), and three targets of stigma (self/child, family, and services)."]

Full text at:

<http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709000252.pdf>

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## SUICIDE PREVENTION

**“Family and Household Formations and Suicide in the United States.” By Justin T. Denny, University Colorado at Boulder. IN: Journal of Marriage and Family, vol. 72, no. 1 (February 2010) pp. 202-213.**

[“Family support systems have been theoretically linked to suicide risk. But no research to date has investigated the effects of detailed living arrangements on individual risk of suicide. Using data on 825,462 adults from the National Health Interview Survey Linked Mortality File reveals that living in families with stronger sources of social support and integration decreases risk of suicide. These effects persist despite controls for important individual level characteristics. Risk of suicide decreases for persons in married as well as unmarried families when children are present and risk increases for persons living with unrelated adults. These results reveal the structural importance of family formation on the social integrative forces that contribute to an individual's risk of suicide.” **NOTE: Please contact the California State Library for a hard copy of this article.**]

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## VETERANS

**“A New Disability for Rehabilitation Counselors: Iraq War Veterans with Traumatic Brain Injury and Post-Traumatic Stress Disorder.” By Hilary S. Burke and others, San Diego State University. IN: Journal of Rehabilitation, vol. 75, no. 3 (April-June 2009) pp. 5-14.**

[“Traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) are considered the "signature" injuries of military personnel serving in the Iraq war. An alarming number of returning veterans are incurring a combination of these two disabilities. TBI and PTSD

combined presents an array of challenges for injured persons that are experienced differently by those separately affected by TBI or PTSD. Hence, the combination of TBI and PTSD presents a new disability classification for the rehabilitation counseling profession. There is an acute need to develop and facilitate specialized care and rehabilitative services for veterans impacted by this nascent disability. We highlight neurobiological, behavioral, and physiological characteristics associated with combat-incurred TBI/PTSD injuries. Additionally, we offer recommendations for rehabilitation counseling professionals and researchers to consider in response to our review of the current system of veteran care, common barriers to rehabilitation and societal re-integration, and available resources for military personnel impacted by TBI and PTSD.”]

Full text at:

<http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=45562876&site=ehost-live>

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**“VA Pharmacy Users: How They Differ from Other Veterans.” By Sherry Aspinall and others, VA Center for Medication Safety. IN: American Journal of Managed Care, vol. 15, no. 10 (October 2009) pp.704-708.**

**[“Objective:** To compare users and nonusers of Veterans Affairs (VA) pharmacy services by age group.

**Study Design:** Cross-sectional.

**Methods:** We used data on sociodemographics, health status, and medical conditions from the Medical Expenditure Panel Survey (MEPS) to compare users and nonusers of VA pharmacies for medications. Data were pooled for 2003-2005 to ensure adequate sample sizes. Student *t* tests were used to compare the means for each variable, and all analyses were adjusted for the complex sample design of the MEPS.

**Results:** Among both nonelderly (18-64 years) and elderly (>65 years) veterans, a higher proportion who used VA pharmacy services versus those who did not use VA pharmacy services (1) were black (nonelderly: 17.7 % vs. 7.4%,  $P < .001$ ; elderly: 9.4% vs. 4.7%,  $P < .001$ ); (2) had no alternative insurance (nonelderly: 27.2% vs. 4.8%,  $P < .001$ ; elderly: 36.3% vs. 19.9%,  $P < .001$ ); (3) had lower incomes (nonelderly: 32.4% vs. 11.5%,  $P < .001$ ; elderly: 32.4% vs. 25.4%,  $P = .01$ ); (4) had less than a high school education (nonelderly: 13.0% vs. 6.5%,  $P < .001$ ; elderly: 27.5% vs. 17.6%,  $P < .001$ ); (5) were disabled; and (6) reported poorer health. A higher percentage of nonelderly users reported a mental health condition (31.6% vs. 19.4%,  $P < .001$ ).

**Conclusions:** Veterans who use VA pharmacy services appear to be more ill than those who do not use VA pharmacy services. In addition, the VA appears to be a safety net for uninsured veterans who have mental health problems.”]

Full text at:

[http://www.ajmc.com/media/pdf/AJMC\\_09Oct\\_Aspinall\\_701to708.pdf](http://www.ajmc.com/media/pdf/AJMC_09Oct_Aspinall_701to708.pdf)

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## GRANT INFORMATION/FUNDING OPPORTUNITIES

[BJA Now Accepting Applications  
for the 2010 Justice and Mental Health Collaboration Program](#)

The Bureau of Justice Assistance (BJA) is currently seeking grant applications for its 2010 Justice and Mental Health Collaboration Program. The Program, authorized by the Mentally Ill Offender Treatment and Crime Reduction Act of 2004, focuses on improving access to effective treatment for adults and juveniles with mental health problems in contact with the justice system by facilitating collaboration among the justice and treatment systems. Three categories of grants are available: 1) Planning Grants; 2) Planning and Implementation Grants; and 3) Implementation and Expansion Grants. Applications are due April 8, 2010. For additional information visit the BJA website at <http://www.ojp.usdoj.gov/BJA/grant/10JMHCPsol.pdf>.

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**The CDC's National Center for Injury Prevention and Control (NCIPC) has a new funding opportunity (also available on [www.grants.gov](http://www.grants.gov)):**

**Prevention of Suicidal Behavior through the Enhancement of Connectedness** (RFA-CE-10-006):

This funding opportunity announcement (FOA) solicits applications from applicant organizations that target one or more modifiable risk factors for suicidal behavior with a primary prevention strategy that is designed to enhance connectedness and to rigorously assess the efficacy or effectiveness of that strategy. **Awards will be up to \$40,000 per year for 5 years, and the application deadline date is April 29, 2010.**

Eligible organizations include: public and private nonprofit organizations; for profit organizations; small, minority, and women-owned businesses; universities; colleges; research institutions; hospitals; community-based organizations; faith-based organizations; federally recognized or state-recognized American Indian/Alaska Native tribal governments; American Indian/Alaska Native tribally designated organizations; Alaska Native health corporations; urban Indian health organizations; tribal epidemiology centers; and state and local governments.

To access the full announcement and application package, please go to:

<http://www07.grants.gov/search/search.do;jsessionid=75hPLjDHzlFyfzZglFstZ93wvmy1wJdsYLxGSGRYpynKsqRKgrgM!-1299818899?oppId=51411&mode=VIEW>.

(Funding Opportunity Number: RFA-CE-10-006; Catalog of Federal Domestic Assistance (CFDA) number: 93.136.). If you have difficulty accessing the full announcement electronically, please contact CDC's Procurement and Grants Office, Technical Information Management, at 770-488-2700 or [PGOTIM@cdc.gov](mailto:PGOTIM@cdc.gov)

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## ONLINE COURSES ON MENTAL HEALTH ISSUES

### Information and registration:

<http://www.cehd.umn.edu/ceed/profdev/onlinecourses/2010OnlineCourseSchedule.pdf>

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## CONFERENCES, MEETINGS AND SEMINARS

### 23rd Annual Children's Mental Health Research and Policy Conference

March 7-10, 2010

Tampa, Florida

For more information:

<http://rtckids.fmhi.usf.edu/cmhconference/>

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**40<sup>th</sup> National Mental Health and Addictions Conference and Expo:** *Experience the Magic.*

March 15-17, 2010

Orlando, Florida

For more information and registration:

[http://www.thenationalcouncil.org/cs/2010\\_registration\\_rates](http://www.thenationalcouncil.org/cs/2010_registration_rates)

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### Association for Applied Psychophysiology and Biofeedback Annual Conference 2010

March 24-27, 2010

San Diego, California

For information:

[http://www.bmedreport.com/archives/9593?utm\\_source=feedburner&utm\\_medium=email&utm\\_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29](http://www.bmedreport.com/archives/9593?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+TheBehavioralMedicineReport+%28The+Behavioral+Medicine+Report%29)

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**43rd American Association of Suicidology Annual Conference:** *Families, Community Systems and Suicide*

April 21st - 24th, 2010

Orlando, Florida

For more information: <http://www.suicidology.org/web/guest/education-and-training/annual-conference>

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